STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE, MERRILLVILLE, , 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00447809 and IN00452292. Complaint IN00447809- No deficiencies related to the allegations are cited. Complaint IN00452292- No deficiencies related to the allegations are cited. Survey dates: February 11 and 12, 2025 Facility number: 014178 Residential Census: 120 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/17/25.	R 0000		
R 0042	Residents' Rights - Noncompliance	R 0042	1. ED placed most recent annual	03/12/2025

	410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on record review and interview, the facility failed to ensure the most recent annual survey results were readily available for review. This had the potential to affect all 120 residents of the facility. Finding includes: The State Survey Binder was reviewed on 2/12/25 at 11:10 a.m. The last annual survey was conducted 12/6/23. The survey results were not available in the binder. During an interview on 2/12/25 at 11:15 a.m., the Administrator indicated she thought she had put the last annual survey results in the binder. She looked through the binder and indicated they were not in there, but she would add them.		survey in binder on 2/12/25. 2. No residents were affected by the alleged deficient practice. 3. ED and/or designee will audit monthly. 4. QAPI committee will review the audit monthly x6 months to ensure the surveys are present at all times. The will be an ongoing audit to ensure the community remains in compliance.	

	Based on record review and interview, the facility failed to ensure the most recent annual survey results were readily available for review. This had the potential to affect all 120 residents of the facility. Finding includes: The State Survey Binder was reviewed on 2/12/25 at 11:10 a.m. The last annual survey was conducted 12/6/23. The survey results were not available in the binder. During an interview on 2/12/25 at 11:15 a.m., the Administrator indicated she thought she had put the last annual survey results in the binder. She looked through the binder and indicated they were not in there, but she would add them.			
R 0045	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following:	R 0045	1. Residents 7 and 8 were discharged safely and had no adverse effects from alleged deficient practice. 2. No adverse effects were reported from discharged residents from last 30 days. 3. ED created internal document to capture transfer disposition per rule 410 IAC 16.2-5-8.1(g)(1-7). Staff to be educated on 2/26/25 on rule and new form to be used for any future voluntary discharges from	03/12/2025

	(i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when:		the community. 4. DON and/or designee will audit use of the form post any discharges and this will be reviewed at monthly QAPI meetings for the next 6 months.	

(A) the safety of individuals in the facility would be endangered;

(B) the health of individuals in the facility would be endangered;

(C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge;

(D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or

(E) a resident has not resided in the facility for thirty (30) days.

(9) For health facilities, the written notice specified in subdivision (7) must include the following:

(A) The reason for transfer or discharge.

(B) The effective date of transfer or discharge.

(C) The location to which the resident is transferred or discharged.

(D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34)

	days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to lack of transfer/discharge documentation for 2 of 3 residents reviewed for transfer/ discharge. (Residents 7 and 8) Finding includes: 1. The closed record for Resident 7 was reviewed on 2/11/25 at 2:48 p.m. Diagnoses included dementia, anxiety and			

hypertension.

A Progress Note, dated 1/12/25, indicated the resident had been transferred to a memory care unit at a different healthcare facility. There was no transfer or discharge paperwork in the record.

During an interview on 2/12/25 at 10:10 a.m., the Administrator indicated it was a family initiated discharge so they did not have to complete transfer/discharge paperwork. She later indicated the paperwork should have been completed.

2. Resident 8's record was reviewed on 2/11/25 at 3:04 p.m. The resident discharged from the facility on 12/26/24. Diagnoses included, but were not limited to, bipolar disorder, mild cognitive impairment, and chronic kidney disease.

A Nurses' Note, dated 12/26/24 at 9:30 a.m., indicated the resident had transitioned out of the building to a skilled nursing facility.

There was a lack of documentation related to transfer/discharge paperwork.

During an interview on 2/12/25 at 10:19 a.m., the Administrator indicated she was creating a transfer/discharge form that would be sent out with any future discharges. She had no

transfer paperwork, as the case management company arranged for the transfer without informing the facility when it would actually occur. There had been communication between the facility and the case management company about transferring the resident due to increased care needs. After that, the case management company took over making the arrangements for transfer.

Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to lack of transfer/discharge documentation for 2 of 3 residents reviewed for transfer/ discharge. (Residents 7 and 8)

Finding includes:

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R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as	R 0217	1. Resident 4's RSP was updated and signed on 02/20/25. Resident 5's RSP was updated and signed on 03/07/25. Resident 6's RSP was updated and signed on 02/26/25. Resident 8 was discharged. 2. Resident service plans were auited by DON and ADON, any service plans lacking services or care needs will have service plans updated and signed by 03/12/25. 3. DON and ADON will meet weekly to review any changes that have happened over the past 7 days and ensure the service plans are updated as needed. DON and/or designee will audit weekly for 4 weeks, bi-weekly for 1 month, and monthly for 4 months.	03/12/2025

	appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure Service Plans were signed and/ or updated with changes related to self medication administration, home health services, hospice services, mental health services and therapy for 4 of 8 service plans reviewed. (Residents 6, 5, 4 and 8) Findings include: 1. Resident 6's record was reviewed on 2/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes		4. Audits will be reviewed by QAPI committee monthly for 6 months and make recommendations as needed.	

	mellitus and chronic obstructive pulmonary disease. The resident was admitted on 10/11/23. The resident had a Quarterly Evaluation on 1/15/25. She also received a Self Medication Assessment and was found to be capable of administering her own medications at that time. The resident's Service Plan had not been updated with changes related to the self administration of medications until requested on 2/11/25. During an interview on 2/11/25 at 2:25 p.m., the Director of Nursing indicated the Service Plan had been reviewed at the time of the quarterly evaluation on 1/15/25, but changes had not been made at that time. 3. Resident 4's record was reviewed on 2/11/25 at 11:13 a.m. Diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, and hypertension. A Physician's Order, dated 1/15/25, indicated hospice to evaluate and treat. A Nurses' Note, dated 1/19/25 at 3:19 p.m., indicated the resident's Power of Attorney (POA) inquired about hospice or palliative care options for the resident. An order was received			

	from the Nurse Practitioner for hospice to evaluate and treat. Paperwork was faxed to a hospice company for them to assess and manage care for the resident. The Resident Service Plan (RSP), signed by the resident on 1/4/24, indicated the resident was seen by psychiatry services and home health services for physical and occupational therapy. The RSP was not updated to reflect the resident receiving hospice services. During an interview on 2/11/25 at 3:09 p.m., the Director of Nursing indicated the Service Plan was not updated to reflect hospice services. 4. Resident 8's record was reviewed on 2/11/25 at 3:04 p.m. Diagnoses included, but were not limited to, bipolar disorder, mild cognitive impairment, and chronic back pain. The Resident Service Plan, dated 11/11/24, indicated the resident displayed short term memory deficits. The Resident Service Plan was not signed by the resident or the responsible party. A Nurses' Note, dated 12/16/24 at 2:52 p.m., indicated the			

therapist was unable to complete the therapy session as ordered due to the resident not being in her apartment or common areas of the community.

A Nurses' note, dated 12/17/24, indicated the psychiatry services Nurse Practitioner had a visit with the resident on this day and reviewed fall history, medications, behavior concerns, and self-care.

There was no documentation, Physician's Orders, or a Service Plan to reflect the resident receiving psychiatric services or therapy services.

During an interview on 2/12/24 at 11:28 a.m., the Director of Nursing indicated the Service Plan should have been updated to reflect the services she was receiving. She was unsure when the resident had started receiving therapy because the medical management company initiated the therapy and used their own therapist.

2. Record review for Resident 5 was completed on 2/12/25 at 9:13 a.m. Diagnoses included, but were not limited to, arthritis, diabetes, benign prostatic hyperplasia, and coronary artery disease.

The resident was admitted to the facility on 12/14/22. On 9/4/24, the resident had a fall

	which resulted in a fracture and was discharged out of the facility to a hospital and then into a nursing home. The resident was admitted back to the facility on 11/4/24 with Home Health Services. The Home Health services were to manage his urinary catheter. A Service Plan, dated 11/5/24, indicated the resident had a catheter. The nursing staff was to empty his catheter as needed. The resident also required assistance with bathing. The plan was signed by the resident. The plan did not include the resident was to receive Home Health Services. During an interview on 2/12/25 at 11:31 a.m., the DON indicated the resident was receiving Home Health services to change his urinary catheter and also to assist with bathing. Home Health services were not listed on his Service Plan but should have been included. Based on record review and interview, the facility failed to ensure Service Plans were signed and/ or updated with changes related to self medication administration, home health services, hospice services, mental health services and therapy for 4 of 8 service plans reviewed. (Residents 6, 5, 4 and 8)			

Findings include:

1. Resident 6's record was reviewed on 2/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic obstructive pulmonary disease. The resident was admitted on 10/11/23.

The resident had a Quarterly Evaluation on 1/15/25. She also received a Self Medication Assessment and was found to be capable of administering her own medications at that time.

The resident's Service Plan had not been updated with changes related to the self administration of medications until requested on 2/11/25.

During an interview on 2/11/25 at 2:25 p.m., the Director of Nursing indicated the Service Plan had been reviewed at the time of the quarterly evaluation on 1/15/25, but changes had not been made at that time.

3. Resident 4's record was reviewed on 2/11/25 at 11:13 a.m. Diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, and hypertension.

A Physician's Order, dated 1/15/25, indicated hospice to evaluate and treat.

	A Nurses' Note, dated 1/19/25 at 3:19 p.m., indicated the resident's Power of Attorney (POA) inquired about hospice or palliative care options for the resident. An order was received from the Nurse Practitioner for hospice to evaluate and treat. Paperwork was faxed to a hospice company for them to assess and manage care for the resident. The Resident Service Plan (RSP), signed by the resident on 1/4/24, indicated the resident was seen by psychiatry services and home health services for physical and occupational therapy. The RSP was not updated to reflect the resident receiving hospice services. During an interview on 2/11/25 at 3:09 p.m., the Director of Nursing indicated the Service Plan was not updated to reflect hospice services. 4. Resident 8's record was reviewed on 2/11/25 at 3:04 p.m. Diagnoses included, but were not limited to, bipolar disorder, mild cognitive impairment, and chronic back pain. The Resident Service Plan, dated 11/11/24, indicated the resident displayed short term memory deficits.			

	The Resident Service Plan was not signed by the resident or the responsible party. A Nurses' Note, dated 12/16/24 at 2:52 p.m., indicated the therapist was unable to complete the therapy session as ordered due to the resident not being in her apartment or common areas of the community. A Nurses' note, dated 12/17/24, indicated the psychiatry services Nurse Practitioner had a visit with the resident on this day and reviewed fall history, medications, behavior concerns, and self-care. There was no documentation, Physician's Orders, or a Service Plan to reflect the resident receiving psychiatric services or therapy services. During an interview on 2/12/24 at 11:28 a.m., the Director of Nursing indicated the Service Plan should have been updated to reflect the services she was receiving. She was unsure when the resident had started receiving therapy because the medical management company initiated the therapy and used their own therapist. 2. Record review for Resident 5 was completed on 2/12/25 at 9:13 a.m. Diagnoses included, but were not limited to, arthritis, diabetes, benign prostatic			

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The resident's Service Plan had not been updated with changes related to the self administration of medications until requested on 2/11/25.

During an interview on 2/11/25 at 2:25 p.m., the Director of Nursing indicated the Service Plan had been reviewed at the time of the quarterly evaluation on 1/15/25, but changes had not been made at that time.

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A Nurses' Note, dated 1/19/25 at 3:19 p.m., indicated the resident's Power of Attorney (POA) inquired about hospice or palliative care options for the resident. An order was received from the Nurse Practitioner for hospice to evaluate and treat. Paperwork was faxed to a hospice company for them to assess and manage care for the resident.

The Resident Service Plan (RSP), signed by the resident on 1/4/24, indicated the resident was seen by psychiatry services and home health services for physical and occupational

	therapy. The RSP was not updated to reflect the resident receiving hospice services. During an interview on 2/11/25 at 3:09 p.m., the Director of Nursing indicated the Service Plan was not updated to reflect hospice services. 4. Resident 8's record was reviewed on 2/11/25 at 3:04 p.m. Diagnoses included, but were not limited to, bipolar disorder, mild cognitive impairment, and chronic back pain. The Resident Service Plan, dated 11/11/24, indicated the resident displayed short term memory deficits. The Resident Service Plan was not signed by the resident or the responsible party. A Nurses' Note, dated 12/16/24 at 2:52 p.m., indicated the therapist was unable to complete the therapy session as ordered due to the resident not being in her apartment or common areas of the community. A Nurses' note, dated 12/17/24, indicated the psychiatry services Nurse Practitioner had a visit with the resident on this day and reviewed fall history, medications, behavior concerns,			

and self-care.

There was no documentation, Physician's Orders, or a Service Plan to reflect the resident receiving psychiatric services or therapy services.

During an interview on 2/12/24 at 11:28 a.m., the Director of Nursing indicated the Service Plan should have been updated to reflect the services she was receiving. She was unsure when the resident had started receiving therapy because the medical management company initiated the therapy and used their own therapist.

2. Record review for Resident 5 was completed on 2/12/25 at 9:13 a.m. Diagnoses included, but were not limited to, arthritis, diabetes, benign prostatic hyperplasia, and coronary artery disease.

The resident was admitted to the facility on 12/14/22. On 9/4/24, the resident had a fall which resulted in a fracture and was discharged out of the facility to a hospital and then into a nursing home. The resident was admitted back to the facility on 11/4/24 with Home Health Services. The Home Health services were to manage his urinary catheter.

A Service Plan, dated 11/5/24, indicated the resident had a catheter. The nursing staff was

to empty his catheter as needed. The resident also required assistance with bathing. The plan was signed by the resident. The plan did not include the resident was to receive Home Health Services.

During an interview on 2/12/25 at 11:31 a.m., the DON indicated the resident was receiving Home Health services to change his urinary catheter and also to assist with bathing. Home Health services were not listed on his Service Plan but should have been included.

Based on record review and interview, the facility failed to ensure Service Plans were signed and/ or updated with changes related to self medication administration, home health services, hospice services, mental health services and therapy for 4 of 8 service plans reviewed. (Residents 6, 5, 4 and 8)

Findings include:

1. Resident 6's record was reviewed on 2/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic obstructive pulmonary disease. The resident was admitted on 10/11/23.

The resident had a Quarterly Evaluation on 1/15/25. She also received a Self Medication

	Assessment and was found to be capable of administering her own medications at that time. The resident's Service Plan had not been updated with changes related to the self administration of medications until requested on 2/11/25. During an interview on 2/11/25 at 2:25 p.m., the Director of Nursing indicated the Service Plan had been reviewed at the time of the quarterly evaluation on 1/15/25, but changes had not been made at that time. 3. Resident 4's record was reviewed on 2/11/25 at 11:13 a.m. Diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, and hypertension. A Physician's Order, dated 1/15/25, indicated hospice to evaluate and treat. A Nurses' Note, dated 1/19/25 at 3:19 p.m., indicated the resident's Power of Attorney (POA) inquired about hospice or palliative care options for the resident. An order was received from the Nurse Practitioner for hospice to evaluate and treat. Paperwork was faxed to a hospice company for them to assess and manage care for the resident. The Resident Service Plan			

	(RSP), signed by the resident on 1/4/24, indicated the resident was seen by psychiatry services and home health services for physical and occupational therapy. The RSP was not updated to reflect the resident receiving hospice services. During an interview on 2/11/25 at 3:09 p.m., the Director of Nursing indicated the Service Plan was not updated to reflect hospice services. 4. Resident 8's record was reviewed on 2/11/25 at 3:04 p.m. Diagnoses included, but were not limited to, bipolar disorder, mild cognitive impairment, and chronic back pain. The Resident Service Plan, dated 11/11/24, indicated the resident displayed short term memory deficits. The Resident Service Plan was not signed by the resident or the responsible party. A Nurses' Note, dated 12/16/24 at 2:52 p.m., indicated the therapist was unable to complete the therapy session as ordered due to the resident not being in her apartment or common areas of the community. A Nurses' note, dated 12/17/24,			

	indicated the psychiatry services Nurse Practitioner had a visit with the resident on this day and reviewed fall history, medications, behavior concerns, and self-care. There was no documentation, Physician's Orders, or a Service Plan to reflect the resident receiving psychiatric services or therapy services. During an interview on 2/12/24 at 11:28 a.m., the Director of Nursing indicated the Service Plan should have been updated to reflect the services she was receiving. She was unsure when the resident had started receiving therapy because the medical management company initiated the therapy and used their own therapist. 2. Record review for Resident 5 was completed on 2/12/25 at 9:13 a.m. Diagnoses included, but were not limited to, arthritis, diabetes, benign prostatic hyperplasia, and coronary artery disease. The resident was admitted to the facility on 12/14/22. On 9/4/24, the resident had a fall which resulted in a fracture and was discharged out of the facility to a hospital and then into a nursing home. The resident was admitted back to the facility on 11/4/24 with Home Health Services. The			

	Home Health services were to manage his urinary catheter. A Service Plan, dated 11/5/24, indicated the resident had a catheter. The nursing staff was to empty his catheter as needed. The resident also required assistance with bathing. The plan was signed by the resident. The plan did not include the resident was to receive Home Health Services. During an interview on 2/12/25 at 11:31 a.m., the DON indicated the resident was receiving Home Health services to change his urinary catheter and also to assist with bathing. Home Health services were not listed on his Service Plan but should have been included.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to	R 0241	1. Resident 8 had no adverse effects from alleged deficient practices. 2. All residents that have medications administered have the potential to be affected by alleged deficient practice. No other residents were negatively affected by alleged deficiencies. 3. DON and ADON completed education and training on 2/26/25 for nursing staff on following physician orders and notifying physicians when resident refuses or is unavailable to administer	03/12/2025

	ensure physician's orders were followed, related to medications not administered as ordered for 1 of 8 residents reviewed. (Resident 8) Finding includes: Resident 8's record was reviewed on 2/11/25 at 3:04 p.m. Diagnoses included, but were not limited to, diabetes mellitus, chronic kidney disease, and bipolar disorder. The Resident Service Plan, dated 11/11/24, indicated the resident had a diagnoses of diabetes mellitus. Interventions included, but were not limited to, assist/administer medications as ordered and monitor for effectiveness. A Physician's Order, dated 9/23/24, indicated the resident received Humalog (insulin injection) 100 unit/milliliter Kwikpen, inject subcutaneously three times daily with meals per sliding scale (dose based on blood sugar (BS) levels): BS 201-250 = 2 units (U), 251-300 = 4U, 301-350 = 8U; and 351-400 = 10U. The December 2024 Medication Administration Record (MAR) indicated the resident had not received the Humalog dose as ordered on 12/1 at 4:00 p.m., 12/10 at 4:00 p.m., 12/11 at 4:00 p.m., 12/12 at 8:00 a.m. and 4:00 p.m., 12/14 at 4:00		medications as ordered. DON and/or designee will audit medication administration weekly for 4 weeks, bi-weekly for 1 month and monthly for 4 months. 4. Audits will be reviewed monthly by QAPI committee for 6 months and make recommendations as needed.	

p.m., and 12/20/24 at 4:00 p.m. Each dose was marked "Away." There were no corresponding notes to indicate the physician was notified.

The December 2024 MAR indicated the resident received the incorrect dose of Humalog on the following dates and times:

- 12/4/24 at 8:00 a.m., the dose administered was blank with a blood sugar of 231. The resident should have received 2U.

- 12/6/24 at 8:00 a.m., the dose administered was marked 2U with a blood sugar of 252. The resident should have received 4U.

- 12/11/24 at 12:00 p.m., the dose administered was marked 0U with a blood sugar of 229. The resident should have received 2U.

- 12/19/24 at 8:00 a.m., the dose administered was blank with a blood sugar of 205. The resident should have received 2U.

During an interview on 2/12/25 at 1:20 p.m., the Director of Nursing indicated she had no further information to provide.

Based on record review and interview, the facility failed to ensure physician's orders were

followed, related to medications not administered as ordered for 1 of 8 residents reviewed. (Resident 8)

Finding includes:

Resident 8's record was reviewed on 2/11/25 at 3:04 p.m. Diagnoses included, but were not limited to, diabetes mellitus, chronic kidney disease, and bipolar disorder.

The Resident Service Plan, dated 11/11/24, indicated the resident had a diagnoses of diabetes mellitus. Interventions included, but were not limited to, assist/administer medications as ordered and monitor for effectiveness.

A Physician's Order, dated 9/23/24, indicated the resident received Humalog (insulin injection) 100 unit/milliliter Kwikpen, inject subcutaneously three times daily with meals per sliding scale (dose based on blood sugar (BS) levels): BS 201-250 = 2 units (U), 251-300 = 4U, 301-350 = 8U; and 351-400 = 10U.

The December 2024 Medication Administration Record (MAR) indicated the resident had not received the Humalog dose as ordered on 12/1 at 4:00 p.m., 12/10 at 4:00 p.m., 12/11 at 4:00 p.m., 12/12 at 8:00 a.m. and 4:00 p.m., 12/14 at 4:00 p.m., and 12/20/24 at 4:00 p.m.

	Each dose was marked "Away." There were no corresponding notes to indicate the physician was notified. The December 2024 MAR indicated the resident received the incorrect dose of Humalog on the following dates and times: - 12/4/24 at 8:00 a.m., the dose administered was blank with a blood sugar of 231. The resident should have received 2U. - 12/6/24 at 8:00 a.m., the dose administered was marked 2U with a blood sugar of 252. The resident should have received 4U. - 12/11/24 at 12:00 p.m., the dose administered was marked 0U with a blood sugar of 229. The resident should have received 2U. - 12/19/24 at 8:00 a.m., the dose administered was blank with a blood sugar of 205. The resident should have received 2U. During an interview on 2/12/25 at 1:20 p.m., the Director of Nursing indicated she had no further information to provide.			

R 0275	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(h) (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. 4. Record review for Resident 5 was completed on 2/12/25 at 9:13 a.m. Diagnoses included, but were not limited to, arthritis, diabetes, benign prostatic hyperplasia, and coronary artery disease. The resident was admitted to the facility on 12/14/22. There was no documentation to indicate what the resident's diet orders were or that they were reviewed by the physician. During an interview on 2/12/25 at 11:31 a.m., the DON indicated she could not provide any documentation of what the resident's diet orders were or that they were reviewed by the physician. 5. Record review for Resident 9 was completed on 2/11/25 at 10:21 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and atrial fibrillation. The resident was admitted to the facility on 3/9/22.	R 0275	1. Residents 2, 3, 4, 5, 6, 7, and 9 diet orders were obtained from provider. No adverse effects noted. 2. All residents have potential to be affected by alleged deficient practice. No other residents were negatively affected by alleged deficient practice. 3. DON and/or designee to fax all physicians and obtain diet orders for residents who currently are issing them. DON obtained updated admission packet to ensure Diet Orders are recieved prior to admission for all future admits. DON and/or designee to fax quarterly to all physicians to ensure diet orders are up to date and accurate. DON and/or designee to audit weekly for 4 weeks, bi-weekly for 1 month, and monthly for 4 months. 4. Audits will be reviewed in monthly QAPI for 6 months and make recommendations as needed.	03/12/2025

There was lack of any physician's order for the resident's diet in the record.

During an interview on 2/11/25 at 2:29 p.m., the DON indicated she had requested a diet order from the physician on 10/17/24 by fax and had not received anything back.

6. Record review for Resident 2 was completed on 2/11/25 at 9:59 a.m. Diagnoses included, but were not limited to, diabetes and high blood pressure.

There was lack of documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25 at 1:10 p.m., the Administrator indicated they had not received diet orders when the resident admitted to the facility. The diet orders were just received today from the in-house physician and would be entered into the chart.

7. Record review for Resident 4 was completed on 2/11/25 at 11:13 a.m. Diagnoses included, but were not limited to, congestive heart failure and high blood pressure.

There was lack of documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25

	at 3:09 p.m., the Director of Nursing indicated there were no diet orders for the resident currently, but she would reach out to the physician and obtain new orders. Based on record review and interview, the facility failed to ensure there was a physician's order for a diet for 7 of 8 residents reviewed for dietary orders. (Residents 3, 6, 7, 5, 9, 2, and 4) Findings include: 1. Resident 3's record was reviewed on 2/11/24 at 10:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation and seizure disorder. The resident was admitted on 1/23/21. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 2. Resident 6's record was reviewed on 2/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic obstructive pulmonary disease. The resident was admitted on 10/11/23.			

	There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 3. The closed record for Resident 7 was reviewed on 2/11/25 at 2:48 p.m. Diagnoses included, but were not limited to, dementia, anxiety and hypertension. The resident was admitted on 6/9/22. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 4. Record review for Resident 5 was completed on 2/12/25 at 9:13 a.m. Diagnoses included, but were not limited to, arthritis, diabetes, benign prostatic hyperplasia, and coronary artery disease. The resident was admitted to the facility on 12/14/22. There was no documentation to indicate what the resident's diet orders were or that they were reviewed by the physician. During an interview on 2/12/25 at 11:31 a.m., the DON indicated she could not provide any documentation of what the resident's diet orders were or			

	that they were reviewed by the physician. 5. Record review for Resident 9 was completed on 2/11/25 at 10:21 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and atrial fibrillation. The resident was admitted to the facility on 3/9/22. There was lack of any physician's order for the resident's diet in the record. During an interview on 2/11/25 at 2:29 p.m., the DON indicated she had requested a diet order from the physician on 10/17/24 by fax and had not received anything back. 6. Record review for Resident 2 was completed on 2/11/25 at 9:59 a.m. Diagnoses included, but were not limited to, diabetes and high blood pressure. There was lack of documentation of any physician's orders for a diet in the record. During an interview on 2/11/25 at 1:10 p.m., the Administrator indicated they had not received diet orders when the resident admitted to the facility. The diet orders were just received today from the in-house physician and would be entered into the chart. 7. Record review for Resident 4			

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disease. The resident was admitted to the facility on 12/14/22.

There was no documentation to indicate what the resident's diet orders were or that they were reviewed by the physician.

During an interview on 2/12/25 at 11:31 a.m., the DON indicated she could not provide any documentation of what the resident's diet orders were or that they were reviewed by the physician.

5. Record review for Resident 9 was completed on 2/11/25 at 10:21 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and atrial fibrillation. The resident was admitted to the facility on 3/9/22.

There was lack of any physician's order for the resident's diet in the record.

During an interview on 2/11/25 at 2:29 p.m., the DON indicated she had requested a diet order from the physician on 10/17/24 by fax and had not received anything back.

6. Record review for Resident 2 was completed on 2/11/25 at 9:59 a.m. Diagnoses included, but were not limited to, diabetes and high blood pressure.

There was lack of

documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25 at 1:10 p.m., the Administrator indicated they had not received diet orders when the resident admitted to the facility. The diet orders were just received today from the in-house physician and would be entered into the chart.

7. Record review for Resident 4 was completed on 2/11/25 at 11:13 a.m. Diagnoses included, but were not limited to, congestive heart failure and high blood pressure.

There was lack of documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25 at 3:09 p.m., the Director of Nursing indicated there were no diet orders for the resident currently, but she would reach out to the physician and obtain new orders.

Based on record review and interview, the facility failed to ensure there was a physician's order for a diet for 7 of 8 residents reviewed for dietary orders. (Residents 3, 6, 7, 5, 9, 2, and 4)

Findings include:

1. Resident 3's record was

	reviewed on 2/11/24 at 10:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation and seizure disorder. The resident was admitted on 1/23/21. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 2. Resident 6's record was reviewed on 2/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic obstructive pulmonary disease. The resident was admitted on 10/11/23. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 3. The closed record for Resident 7 was reviewed on 2/11/25 at 2:48 p.m. Diagnoses included, but were not limited to, dementia, anxiety and hypertension. The resident was admitted on 6/9/22. There was no physician's order for a diet in the record. During an interview on 2/12/25			

at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet.

4. Record review for Resident 5 was completed on 2/12/25 at 9:13 a.m. Diagnoses included, but were not limited to, arthritis, diabetes, benign prostatic hyperplasia, and coronary artery disease. The resident was admitted to the facility on 12/14/22.

There was no documentation to indicate what the resident's diet orders were or that they were reviewed by the physician.

During an interview on 2/12/25 at 11:31 a.m., the DON indicated she could not provide any documentation of what the resident's diet orders were or that they were reviewed by the physician.

5. Record review for Resident 9 was completed on 2/11/25 at 10:21 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and atrial fibrillation. The resident was admitted to the facility on 3/9/22.

There was lack of any physician's order for the resident's diet in the record.

During an interview on 2/11/25 at 2:29 p.m., the DON indicated she had requested a diet order from the physician on 10/17/24

by fax and had not received anything back.

6. Record review for Resident 2 was completed on 2/11/25 at 9:59 a.m. Diagnoses included, but were not limited to, diabetes and high blood pressure.

There was lack of documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25 at 1:10 p.m., the Administrator indicated they had not received diet orders when the resident admitted to the facility. The diet orders were just received today from the in-house physician and would be entered into the chart.

7. Record review for Resident 4 was completed on 2/11/25 at 11:13 a.m. Diagnoses included, but were not limited to, congestive heart failure and high blood pressure.

There was lack of documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25 at 3:09 p.m., the Director of Nursing indicated there were no diet orders for the resident currently, but she would reach out to the physician and obtain new orders.

Based on record review and

	interview, the facility failed to ensure there was a physician's order for a diet for 7 of 8 residents reviewed for dietary orders. (Residents 3, 6, 7, 5, 9, 2, and 4) Findings include: 1. Resident 3's record was reviewed on 2/11/24 at 10:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation and seizure disorder. The resident was admitted on 1/23/21. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 2. Resident 6's record was reviewed on 2/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic obstructive pulmonary disease. The resident was admitted on 10/11/23. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 3. The closed record for Resident 7 was reviewed on			

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There was lack of documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25 at 3:09 p.m., the Director of Nursing indicated there were no diet orders for the resident currently, but she would reach out to the physician and obtain new orders.

Based on record review and interview, the facility failed to ensure there was a physician's order for a diet for 7 of 8 residents reviewed for dietary orders. (Residents 3, 6, 7, 5, 9, 2, and 4)

Findings include:

1. Resident 3's record was reviewed on 2/11/24 at 10:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation and seizure disorder. The resident was admitted on 1/23/21.

There was no physician's order for a diet in the record.

During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet.

2. Resident 6's record was reviewed on 2/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic obstructive

pulmonary disease. The resident was admitted on 10/11/23.

There was no physician's order for a diet in the record.

During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet.

3. The closed record for Resident 7 was reviewed on 2/11/25 at 2:48 p.m. Diagnoses included, but were not limited to, dementia, anxiety and hypertension. The resident was admitted on 6/9/22.

There was no physician's order for a diet in the record.

During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet.

4. Record review for Resident 5 was completed on 2/12/25 at 9:13 a.m. Diagnoses included, but were not limited to, arthritis, diabetes, benign prostatic hyperplasia, and coronary artery disease. The resident was admitted to the facility on 12/14/22.

There was no documentation to indicate what the resident's diet orders were or that they were reviewed by the physician.

During an interview on 2/12/25

at 11:31 a.m., the DON indicated she could not provide any documentation of what the resident's diet orders were or that they were reviewed by the physician.

5. Record review for Resident 9 was completed on 2/11/25 at 10:21 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and atrial fibrillation. The resident was admitted to the facility on 3/9/22.

There was lack of any physician's order for the resident's diet in the record.

During an interview on 2/11/25 at 2:29 p.m., the DON indicated she had requested a diet order from the physician on 10/17/24 by fax and had not received anything back.

6. Record review for Resident 2 was completed on 2/11/25 at 9:59 a.m. Diagnoses included, but were not limited to, diabetes and high blood pressure.

There was lack of documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25 at 1:10 p.m., the Administrator indicated they had not received diet orders when the resident admitted to the facility. The diet orders were just received today

from the in-house physician and would be entered into the chart.

7. Record review for Resident 4 was completed on 2/11/25 at 11:13 a.m. Diagnoses included, but were not limited to, congestive heart failure and high blood pressure.

There was lack of documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25 at 3:09 p.m., the Director of Nursing indicated there were no diet orders for the resident currently, but she would reach out to the physician and obtain new orders.

Based on record review and interview, the facility failed to ensure there was a physician's order for a diet for 7 of 8 residents reviewed for dietary orders. (Residents 3, 6, 7, 5, 9, 2, and 4)

Findings include:

1. Resident 3's record was reviewed on 2/11/24 at 10:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation and seizure disorder. The resident was admitted on 1/23/21.

There was no physician's order for a diet in the record.

	During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 2. Resident 6's record was reviewed on 2/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic obstructive pulmonary disease. The resident was admitted on 10/11/23. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 3. The closed record for Resident 7 was reviewed on 2/11/25 at 2:48 p.m. Diagnoses included, but were not limited to, dementia, anxiety and hypertension. The resident was admitted on 6/9/22. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 4. Record review for Resident 5 was completed on 2/12/25 at 9:13 a.m. Diagnoses included, but were not limited to, arthritis, diabetes, benign prostatic hyperplasia, and coronary artery			

disease. The resident was admitted to the facility on 12/14/22.

There was no documentation to indicate what the resident's diet orders were or that they were reviewed by the physician.

During an interview on 2/12/25 at 11:31 a.m., the DON indicated she could not provide any documentation of what the resident's diet orders were or that they were reviewed by the physician.

5. Record review for Resident 9 was completed on 2/11/25 at 10:21 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and atrial fibrillation. The resident was admitted to the facility on 3/9/22.

There was lack of any physician's order for the resident's diet in the record.

During an interview on 2/11/25 at 2:29 p.m., the DON indicated she had requested a diet order from the physician on 10/17/24 by fax and had not received anything back.

6. Record review for Resident 2 was completed on 2/11/25 at 9:59 a.m. Diagnoses included, but were not limited to, diabetes and high blood pressure.

There was lack of

documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25 at 1:10 p.m., the Administrator indicated they had not received diet orders when the resident admitted to the facility. The diet orders were just received today from the in-house physician and would be entered into the chart.

7. Record review for Resident 4 was completed on 2/11/25 at 11:13 a.m. Diagnoses included, but were not limited to, congestive heart failure and high blood pressure.

There was lack of documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25 at 3:09 p.m., the Director of Nursing indicated there were no diet orders for the resident currently, but she would reach out to the physician and obtain new orders.

Based on record review and interview, the facility failed to ensure there was a physician's order for a diet for 7 of 8 residents reviewed for dietary orders. (Residents 3, 6, 7, 5, 9, 2, and 4)

Findings include:

1. Resident 3's record was

	reviewed on 2/11/24 at 10:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation and seizure disorder. The resident was admitted on 1/23/21. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 2. Resident 6's record was reviewed on 2/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic obstructive pulmonary disease. The resident was admitted on 10/11/23. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 3. The closed record for Resident 7 was reviewed on 2/11/25 at 2:48 p.m. Diagnoses included, but were not limited to, dementia, anxiety and hypertension. The resident was admitted on 6/9/22. There was no physician's order for a diet in the record. During an interview on 2/12/25			

at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet.

4. Record review for Resident 5 was completed on 2/12/25 at 9:13 a.m. Diagnoses included, but were not limited to, arthritis, diabetes, benign prostatic hyperplasia, and coronary artery disease. The resident was admitted to the facility on 12/14/22.

There was no documentation to indicate what the resident's diet orders were or that they were reviewed by the physician.

During an interview on 2/12/25 at 11:31 a.m., the DON indicated she could not provide any documentation of what the resident's diet orders were or that they were reviewed by the physician.

5. Record review for Resident 9 was completed on 2/11/25 at 10:21 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and atrial fibrillation. The resident was admitted to the facility on 3/9/22.

There was lack of any physician's order for the resident's diet in the record.

During an interview on 2/11/25 at 2:29 p.m., the DON indicated she had requested a diet order from the physician on 10/17/24

by fax and had not received anything back.

6. Record review for Resident 2 was completed on 2/11/25 at 9:59 a.m. Diagnoses included, but were not limited to, diabetes and high blood pressure.

There was lack of documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25 at 1:10 p.m., the Administrator indicated they had not received diet orders when the resident admitted to the facility. The diet orders were just received today from the in-house physician and would be entered into the chart.

7. Record review for Resident 4 was completed on 2/11/25 at 11:13 a.m. Diagnoses included, but were not limited to, congestive heart failure and high blood pressure.

There was lack of documentation of any physician's orders for a diet in the record.

During an interview on 2/11/25 at 3:09 p.m., the Director of Nursing indicated there were no diet orders for the resident currently, but she would reach out to the physician and obtain new orders.

Based on record review and

	interview, the facility failed to ensure there was a physician's order for a diet for 7 of 8 residents reviewed for dietary orders. (Residents 3, 6, 7, 5, 9, 2, and 4) Findings include: 1. Resident 3's record was reviewed on 2/11/24 at 10:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation and seizure disorder. The resident was admitted on 1/23/21. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 2. Resident 6's record was reviewed on 2/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic obstructive pulmonary disease. The resident was admitted on 10/11/23. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet. 3. The closed record for Resident 7 was reviewed on			

	2/11/25 at 2:48 p.m. Diagnoses included, but were not limited to, dementia, anxiety and hypertension. The resident was admitted on 6/9/22. There was no physician's order for a diet in the record. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no physician's order for a diet.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 4. Record review for Resident 5 was completed on 2/12/25 at 9:13 a.m. Diagnoses included, but were not limited to, arthritis, diabetes, benign prostatic hyperplasia, and coronary artery disease. The resident was admitted to the facility on 12/14/22.	R 0409	1. Residents 2, 3, 4, 5, 6, 7, and 8 Annual Health Statement were obtained from provider. 2. All residents that do not have annual statement have potential to be affected by alleged deficient practice. No other residents were negatively affected by alleged deficient practice. 3.DON and ADON completed an audit of all resident charts to determine who was missing Annual Health Statements. DON and/or designee to fax all physicians and obtain Annual Health Statements for residents who currently are missing them. DON obtained updated admission packet to ensure Annual Health Statements are received prior to admission for all future admits. DON and/or designee to fax quarterly to all physicians to ensure Annual Health Statements are received at least annually. DON and/or designee to audit weekly for 4 weeks, bi-weekly	03/12/2025

	There was no documentation to indicate an Annual Health Statement that the resident was free of communicable diseases had been completed. During an interview on 2/12/25 at 11:31 a.m., the DON indicated she could not provide any documentation an Annual Health Statement had been completed. Based on record review and interview, the facility failed to ensure each resident had a signed annual health statement for 7 of 8 records reviewed for annual health statements. (Residents 3, 6, 7, 5, 2, 4 and 8) Findings include: 1. Resident 3's record was reviewed on 2/11/24 at 10:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation and seizure disorder. The resident was admitted on 1/23/21. There was no documentation an Annual Health Statement had been completed. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no Annual Health Statement for the resident. 2. Resident 6's record was reviewed on 2/11/25 at 9:45 a.m. Diagnoses included, but		for 1 month, monthly for 4 month. 4. Audits will be reviewed in monthly QAPI for 6 months and make recommendations as needed.	

were not limited to, diabetes mellitus and chronic obstructive pulmonary disease. The resident was admitted on 10/11/23.

There was no documentation an Annual Health Statement had been completed.

During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no Annual Health Statement for the resident.

3. The closed record for Resident 7 was reviewed on 2/11/25 at 2:48 p.m. Diagnoses included, but were not limited to, dementia, anxiety and hypertension. The resident was admitted on 6/9/22.

There was no documentation an Annual Health Statement had been completed.

During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no Annual Health Statement for the resident.

5. Resident 2's record was reviewed on 2/11/25 at 9:59 a.m. The resident was admitted to the facility on 1/14/25. Diagnoses included, but were not limited to, diabetes and high blood pressure.

The record lacked a health statement to indicate the

resident was free of communicable diseases.

During an interview on 2/11/25 at 11:40 a.m., the Director of Nursing indicated she did not have an annual health statement and would reach out the physician for an order.

6. Resident 4's record was reviewed on 2/11/25 at 11:13 a.m. The resident was admitted to the facility on 6/11/21. Diagnoses included, but were not limited to, congestive heart failure and high blood pressure.

The record lacked a health statement to indicate the resident was free of communicable diseases.

During an interview on 2/11/25 at 3:09 p.m., the Director of Nursing indicated the resident did not have an annual health statement.

7. Resident 8's record was reviewed on 2/11/25 at 3:04 p.m. The resident was admitted to the facility on 8/13/24. Diagnoses included, but were not limited to, bipolar disorder and diabetes mellitus.

The record lacked a health statement to indicate the resident was free of communicable diseases.

During an interview on 2/12/25 at 10:03 a.m., the Director of

Nursing indicated the resident did not have an annual health statement.

4. Record review for Resident 5 was completed on 2/12/25 at 9:13 a.m. Diagnoses included, but were not limited to, arthritis, diabetes, benign prostatic hyperplasia, and coronary artery disease. The resident was admitted to the facility on 12/14/22.

There was no documentation to indicate an Annual Health Statement that the resident was free of communicable diseases had been completed.

During an interview on 2/12/25 at 11:31 a.m., the DON indicated she could not provide any documentation an Annual Health Statement had been completed.

Based on record review and interview, the facility failed to ensure each resident had a signed annual health statement for 7 of 8 records reviewed for annual health statements. (Residents 3, 6, 7, 5, 2, 4 and 8)

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3. The closed record for Resident 7 was reviewed on 2/11/25 at 2:48 p.m. Diagnoses included, but were not limited to, dementia, anxiety and hypertension. The resident was admitted on 6/9/22.

There was no documentation an Annual Health Statement had been completed.

During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no Annual Health Statement for the resident.

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The record lacked a health statement to indicate the resident was free of communicable diseases.

During an interview on 2/12/25 at 10:03 a.m., the Director of Nursing indicated the resident did not have an annual health statement.

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There was no documentation an Annual Health Statement had been completed.

During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no Annual Health Statement for the resident.

2. Resident 6's record was reviewed on 2/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic obstructive

	pulmonary disease. The resident was admitted on 10/11/23. There was no documentation an Annual Health Statement had been completed. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no Annual Health Statement for the resident. 3. The closed record for Resident 7 was reviewed on 2/11/25 at 2:48 p.m. Diagnoses included, but were not limited to, dementia, anxiety and hypertension. The resident was admitted on 6/9/22. There was no documentation an Annual Health Statement had been completed. During an interview on 2/12/25 at 10:10 a.m., the Director of Nursing indicated there was no Annual Health Statement for the resident. 5. Resident 2's record was reviewed on 2/11/25 at 9:59 a.m. The resident was admitted to the facility on 1/14/25. Diagnoses included, but were not limited to, diabetes and high blood pressure.			

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There was no documentation to indicate an Annual Health Statement that the resident was free of communicable diseases had been completed.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE